

# Willow's Edge Massage Therapy

## Confidential Intake Form

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_

City \_\_\_\_\_

Cell Phone \_\_\_\_\_

State \_\_\_\_\_

Email Address \_\_\_\_\_

Zip \_\_\_\_\_

(Unless you don't have email, I will be following up with you by email if you are here for deep tissue or an injury related session.)

### **MEDICAL HISTORY AND INFORMATION**

#### **Circle all that apply**

Headaches

Chronic Pain

Varicose Veins

Vision Problems

Muscle/Joint Pain

Blood Clots

Sinus Problems

Numbness/tingling

Fatigue

High/Low Blood Pressure

Cancer/tumors

Sleep Difficulties

Allergies

Pregnant

Tendonitis

Depression

Toe Fungus

Skin Problems

Athlete's Foot

Hepatitis A , B or C

HIV/AIDS

Herpes (Cold Sores)

Diabetes

Fibromyalgia

Other Medical Conditions not listed above \_\_\_\_\_

List physical activities you partake in regularly \_\_\_\_\_

List previous major injuries/surgeries \_\_\_\_\_

Are you receiving any other treatments such as acupuncture, physical therapy, chiropractic, naturopathic? \_\_\_\_\_

Occupation \_\_\_\_\_

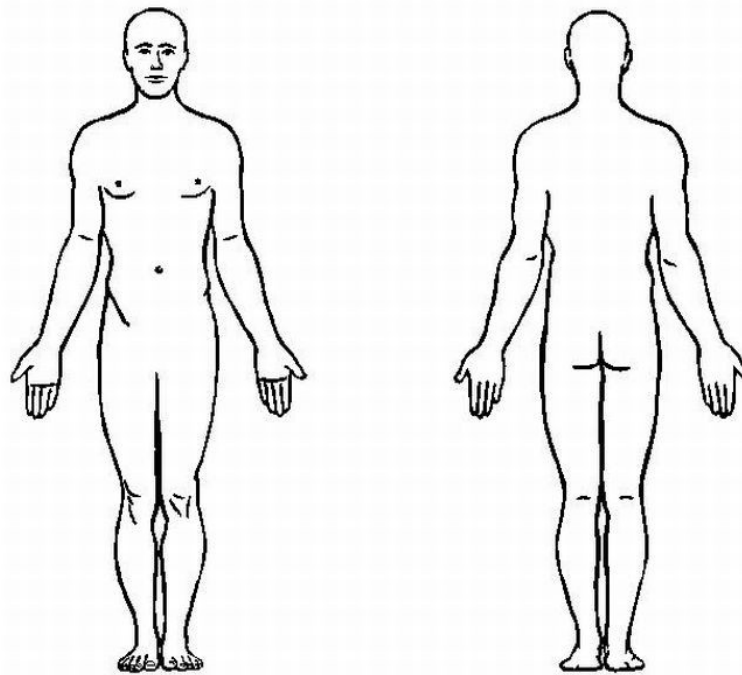
What is your main activity at work? (Circle all that apply)

Phone    Sitting    Computer work    Driving Car    Walking    Lifting?

What do you do to relieve stress? \_\_\_\_\_

What is your purpose for your session today? \_\_\_\_\_

Please Mark where you feel pain or have other issues



I am responsible for all changes for all services provided. I understand the benefits and risks of massage and give my consent for massage. I will consult my practitioner with any questions or concerns immediately. I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes. I agree to provide 24 hour cancellation notice. If I fail to do so, I agree to pay the full appointment fee.

**\*Any illicit or sexually suggestive remarks or advances will result in immediate termination of the treatment.**

Signature \_\_\_\_\_ Date \_\_\_\_\_